

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Wells

154

06333

Reg. Diat. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 Hour  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 1 Hour

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 226 So. Mulberry St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

FREDERICK EARL ANDREWS

## 3. (b) Social Security Number

314-09-6806

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Barbara  
 6.(c) If alive, give age: 40 years  
 7. Birth date of deceased (mo., day, yr.) January 31, 1906  
 8. AGE: Years 41 Months 5 Days 11 It less than one day hrs. min.  
 9. Birthplace Hagerstown, Washington Co., Md.  
 (Town, county, and state)  
 10. Usual occupation Silk Weaver  
 11. Industry or business Hagerstown Ribbon Co.

MOTHER FATHER  
 12. Name Fredrick A. Andrews  
 13. Birthplace Hagerstown Md.  
 14. Maiden name Mary Bowers  
 15. Birthplace Hagerstown Md.

16. Informant Fredrick Andrews  
 Address Hagerstown Md.

17. Burial Date thereof 7/15/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. July 15, 1947 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 13, 19 47 at 12:05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 47, to 19 47,  
 and that I last saw him alive on 19 47

Immediate cause of death Open fractures of skull DURATION 2hrs

Due to Open fractures of skull

Due to Open fractures of skull

Other conditions Open fractures of skull

(Include pregnancy within 3 months of death)

Major findings of operations Open fractures of skull

Date of op. July 13'47

Autopsy results July 13'47

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide HOMICIDE Date of 7/13/47

Where did injury occur HAGERSTOWN WASH. MD.

GARAGE, REAR OF 218 E. ANTIETAM ST.

Injured at home, farm, industry, public place (where?) Garage

Beaten over head with mallet? No

Medical injury No

Signature S. Robert Wells DEPUTY MEDICAL EXAM.

23. SIGNATURE S. Robert Wells WASH. CO., MD.

Address HAGERSTOWN, MD. Date signed 7/14/47

**RECEIVED**

JUL 17 1947

**BUREAU OF**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Wells

06334

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 HoursHospital, institution, or street address where death occurred:  
Washington County HospitalHow long in hospital or institution? 48 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Boonsboro  
(If outside city or town limits, write RURAL and give nearest town)Street No. Main st.

(If rural, give LOCATION)

None2.(a) If veteran, name war None

## 3.(a) FULL NAME

MATHIAS N. BARKER

## 3.(b) Social Security Number

213-12-7195

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male white Divorced

6.(b) Name of husband or wife Carrie6.(c) If alive, give age 65 years7. Birth date of deceased (mo., day, yr.) June 15 18798. AGE: Years Months Days If less than one day  
68 1 4 hrs. min.9. Birthplace Berkeley Springs Morgan Co. W.  
(Town, county, and state)10. Usual occupation Laborer11. Industry or business Victor Products Co.12. Name Charles Barker13. Birthplace Berkeley Springs W. Va.14. Maiden name Emily K. Place15. Birthplace Berkeley Springs W. Va.18. Informant Mary snidemillerAddress Berkeley Springs W. Va.17. Burial Date thereof 7/21/47  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Green Way CemeteryLocation Berkeley Springs W. Va.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. July 20, 1947  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

EDT

20. DATE OF DEATH July 19 1947 19... al 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19... to 19... and that I last saw him alive on 19...

Immediate cause of death

DURATION

auricular fibrillation

Va. cardiac hypertrophy

Nodular benign goiter

Due to acute ventricular fibrillation

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above July 19 '47

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Robert Wells DEPUTY MEDICAL EXAM.Hagerstown, Md. WASH. CO., MD.Address Hagerstown, Md. Date signed July 19-47

RECEIVED  
JUL 22 1947  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Life correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. baptisti

151

06335  
Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 16 Hours

Hospital, institution, or street address where death occurred:

Washington county HospitalHow long in hospital or institution? 16 Hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 56 Mealey parkway

(If rural, give LOCATION)

2.(a) If veteran, name war ---

## 3. (a) FULL NAME

JOHN BARTHOLOMAEUS JR.

## 3. (b) Social Security Number

---

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife ---6. (c) If alive, give age --- years7. Birth date of deceased (mo., day, yr.) July 9 1947

8. AGE: Years Months Days If less than one day

---------16 hrs. min.9. Birthplace Hagerstown Wash. co. Md.  
(Town, county, and state)10. Usual occupation Infant11. Industry or business ---12. Name John Bartholomaeus Sr.13. Birthplace Baltimore Md.14. Maiden name Josephine I. Traynor15. Birthplace Baltimore Md.16. Informant John Bartholomaeus Sr.Address Hagerstown Md.17. Burial Date thereof 7/10/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. July 10 19 47 W. H. Bowers  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1947 19 --- at 1 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7/9 19 47 to 7/10 19 47and that I last saw him alive on 7/10 19 47Immediate cause of death atelectasisDue to prematurityDue to ---Other conditions ---

(Include pregnancy within 8 months of death)

Major findings of operations ---Date of op. ---Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---Where did injury occur? --- (City or town) (County) (State)Injured at home, farm, industry, public place (where?) ---Means of injury --- Injured at work? ---23. SIGNATURE W. H. Bowers M. D. or otherAddress Hagerstown, Md. Date signed 7/10/47

RECEIVED  
JUL 12 1947  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Conrad

06336

Reg. Dist. No. 303

## 1. PLACE OF DEATH:

County WashingtonCity or town Breathedsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 Months

Hospital, institution, or street address where death occurred:

Md. State Reformatory for MalesHow long in hospital or institution? 5 months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Stockton  
(If outside city or town limits, write RURAL and give nearest town)Street No. -----  
(If rural, give LOCATION)2.(a) If veteran, name war World War # 1

## 3. (a) FULL NAME

CHARLES BATES

## 3. (b) Social Security Number

Unable to Locate

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Colored Divorced6. (b) Name of husband or wife Sarah7. Birth date of deceased (mo., day, yr.) May 7 18958. (c) If alive, give age 51 years8. AGE: Years 52 Months 2 Days 4 If less than one day  
.....hrs. ....min.9. Birthplace Bowling Green Caroline Co. Va.  
(Town, county, and state)10. Usual occupation Laborer11. Industry or business ---12. Name No Record13. Birthplace No Record14. Maiden name No Record15. Birthplace No Record16. Informant Files of Md State Ref. for MalesAddress Breathedsville Md.17. Removal Date thereof 7/12/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. Laws CemeteryLocation Philadelphia, Delaware Co. Pa.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. July 12, 1947 John H. Bost  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1947 19..... at 3 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
May 1 1947 to July 11 1947and that I last saw him alive on July 10 1947

Immediate cause of death..... DURATION

Pulm. Tuberculosis 6 mo.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

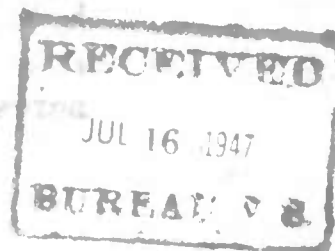
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert P. Conrad M.D. M. D. or otherAddress Hagerstown, Md. Date signed 7-12-47





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 306

## 1. PLACE OF DEATH:

County WashingtonCity or town Smithsburg  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 16 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Lydia Alice Blickenstaff

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 5, 18838. AGE: Years 64 Months 0 Days 0 if less than one day  
..... hrs. .... min.9. Birthplace Nr. Myersville, Fred. Co. Md.  
(Town, county, and state)10. Usual occupation Domestic11. Industry or business Own Home12. Name George W. Blickenstaff13. Birthplace Md.14. Maiden name Mary E. Showe15. Birthplace Md.16. Informant Mrs. Ray Cartee  
Address Smithsburg, Md.17. Burial Date thereof July 8, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Grossnickle'sLocation Nr. Myersville, Md.18. Funeral director Paul F. BittleAddress Myersville, Md.19. July 6 1947 Geo. W. Ferguson  
(Date rec'd by registrar) (local) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Smithsburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1947 at 11:30A. M. E.D.T21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
..... 19....., to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death

Vascular HypertensionDue to Hemiplegia 2 yrsDue to Chr. myocarditisacute ventricular fibrillation

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results NO

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide NO Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

DEPUTY MEDICAL EXAM.

23. SIGNATURE Robert Wells M. D. or otherAddress Hagerstown, Md. Date signed July 6-47

RECEIVED

JUL 16 1947

BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

06338

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 665 Forest Drive  
 (If rural, give LOCATION)

2. (a) If veteran, name war.

## 3. (a) FULL NAME

Annie Sophia Broadus

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Adam B. Broadus

7. Birth date of

deceased (mo., day, yr.)

January 2, 1852

8. AGE:

95 Years6 Months5 Days

if less than one day

hrs.

min.

9. Birthplace

St. James Wash. Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. July 9, 47

(Date rec'd by registrar)

19. 47

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

July 7, 1947 at 9:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 7, 1947 to July 7, 1947and that I last saw him alive on March 7, 1947

Immediate cause of death

Cerebral Hemorrhage

DURATION

1 hr

Diagnosis

General arteriosclerosis

Indef.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B. B. Wheeler

M. D. or other

Address Hagerstown Md.Date signed 7/9/47

RECEIVED

JUL 11 1947

BUREAU OF A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

458

06340

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington  
City or town Hagerstown, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 30 years  
Hospital, institution, or street address where death occurred:  
128 North Locust Street  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 128 North Locust Street  
(If rural, give LOCATION)  
2. (a) If veteran, name war

3. (a) FULL NAME

James Adrian Buckingham

3. (b) Social Security Number

214-09-7673

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Hattie B. Buckingham  
7. Birth date of deceased (mo., day, yr.) February 6, 1890  
6. (c) If alive, give age 57 years  
8. AGE: Years 57 Months 5 Days 25 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31, 1947 at 6:50 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 7, 1945 to July 31, 1947  
and that I last saw him alive on July 30, 1947  
Immediate cause of death Squamous Carcinoma  
Grade # 2 of Tongue  
Due to Tobacco Smoking  
Other conditions \_\_\_\_\_  
DURATION Nov 7, 1945  
5-2-46

9. Birthplace Williamsport, Maryland  
(Town, county, and state)  
10. Usual occupation Truck Driver  
11. Industry or business J. W. Myers & Co.  
12. Name George E. Buckingham  
13. Birthplace Westminster, Maryland  
14. Maiden name Annie Nitzell  
15. Birthplace Williamsport, Maryland

16. Informant Mrs. J. A. Buckingham  
Address Hagerstown, Maryland  
17. Burial Date thereof 8-2-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Riverview Cemetery  
Location Williamsport, Maryland  
18. Funeral director C. M. Suter & Sons  
Address Hagerstown, Maryland  
19. Aug. 1, 1947 Registrar W. Howard Yeager  
(Date rec'd by registrar)

(Include pregnancy within 3 months of death)  
Major findings of operations None  
Autopsy results No  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
23. SIGNATURE W. Howard Yeager M. D. or other \_\_\_\_\_  
Address Hagerstown, Md Date signed July 31, 1947

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If not correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 063462

1. PLACE OF DEATH  
 County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 1/2 days  
 Hospital, institution or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 4 1/2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State... West Va. County... Jefferson  
 City or town... Shepherdstown (If Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None ✓

3. (a) FULL NAME Charles Joshua Cavalier, III  
Baby Boy Cavalier  
 3. (b) Social Security Number None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) July 5, 1947 8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 0 Months 0 Days 4 1/2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Hagerstown, Washington Co., Md.  
 (Town, county, and state)

10. Usual occupation None

11. Industry or business None

12. Name David Taylor Cavalier

13. Birthplace Charles Town, West Va.

14. Maiden name Doris Ball

15. Birthplace Baltimore, Md.

16. Informant David J. Cavalier

Address P.O. Shepherdstown, West Va.

17. Burial Date thereof July 10, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fairview Cemetery

Location Bellevue, West Va.

18. Funeral director Melvin T. Stender

Address Charles Town, West Va.

19. July 12, 1947 Registrar Blas H. Brown  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 9, 1947 at 5:13 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7:15 19 47 to 2:19 19 47  
 and that I last saw him alive on 7:19 19 47

Immediate cause of death Erythroblastosis

Due to \_\_\_\_\_ DURATION \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Blas H. Brown M.D. or other \_\_\_\_\_

Address Hagerstown, Md. Date signed 7/10/47



RECEIVED

JUL 15 1947

BURBANK 8



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

06342

304

## 1. PLACE OF DEATH:

County WashingtonCity or town Hancock  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Main Street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hancock, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. Main Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Pleasant Mecy Clevenger

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Amos O. Clevenger

## 7. Birth date of deceased (mo., day, yr.)

July 12, 1869

6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years 77Months 11Days 25

If less than one day

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 9. Birthplace

Washington County, Md.

(Town, county, and state)

## 10. Usual occupation

Home Duties

## 11. Industry or business

MOTHER FATHER

## 12. Name

Ignatius Robey

## 13. Birthplace

Maryland

## 14. Maiden name

Elizabeth Deneen

## 15. Birthplace

Maryland

## 16. Informant

Mrs. Madeline Smith

## Address

Hancock, Md.

## 17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

July 10, 1947

(month) (day) (year)

## Cemetery or crematory

Mt. Olivet Cemetery

## Location

Near Hancock Route 40 W

## 18. Funeral director

Snyder-Rowland

## Address

Hancock, Md.

## 19.

7-10 47

(Date rec'd by registrar)

J. A. Heller

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1947 19\_\_\_\_ at \_\_\_\_ P. \_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

or 7/7/47 to 7/7/47 19\_\_\_\_and that I last saw him alive on 7/7/47 19\_\_\_\_

## Immediate cause of death

Cardiac Bacteremia

## DURATION

Unknown

## Due to

Presumably Pleurothoracic  
infection

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

## 23. SIGNATURE

J. A. Heller MD

M. D. or other \_\_\_\_\_

## Address

Hancock MdDate signed 7/7/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Hornbaker

06343

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 Day  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 1 Day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 901 Hamilton Boulevard  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

DAVID RAYMOND COFFMAN

## 3. (b) Social Security Number

214-09-3711

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Willia Landis  
 7. Birth date of deceased (mo., day, yr.) May 17, 1877  
 6.(c) If alive, give age 68 years  
 8. AGE: Years 70 Months 1 Days 20 If less than one day -- hrs. -- min.

9. Birthplace Williamsport, Washington Co., Md.  
 (Town, county, and state)  
 10. Usual occupation Manager  
 11. Industry or business Coffman Lumber Co.

FATHER  
 12. Name Peter Coffman  
 13. Birthplace Fairplay Md.  
 MOTHER  
 14. Maiden name Catherine Zittle  
 15. Birthplace Boonsboro, Md

16. Informant R. Landis Coffman  
 Address Hagerstown Md.

17. Burial Date thereof 7/9/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rest Haven Cemetery  
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. July 9, 47 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 19 47 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-1-39, to 7-7-47  
 and that I last saw him alive on 7-7-47

Immediate cause of death  
Acute coronary occlusion

Due to hypertension Cardiovascular disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John H. Hornbaker M.D.Address 154 W. Washington St. M. D. or otherAddress Hagerstown Md. Date signed 7/8/47

RECEIVED

JUL 11 1947

BUREAU 7 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Wells

06344

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 29 YearsHospital, institution, or street address where death occurred:  
424 Guilford Ave.How long in hospital or institution? --

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 424 Guilford Ave.  
(If rural, give LOCATION)2.(a) If veteran, name war None

## 3. (a) FULL NAME

LLOYD FRANKLIN COFFMAN

## 3. (b) Social Security Number

214-09-46004. Sex Male5. Color or race White6.(a) Single, married, widowed, or divorced Divorced6.(b) Name of husband or wife Lillian6.(c) If alive, give age 46 years7. Birth date of deceased (mo., day, yr.) December 20, 19008. AGE: Years 46 Months 6 Days 12 If less than one day hrs. min.9. Birthplace Luray, Page Co. Virginia  
(Town, county, and state)10. Usual occupation Painter11. Industry or business Wolf Contracting12. Name Isaac D. Coffman13. Birthplace Browntown Va.14. Maiden name Allie Jenkins15. Birthplace Groves Mill Va.16. Informant Mrs. Isaac CoffmanAddress Hagerstown Md.17. Burial Burial Date thereof 7/4/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.Date rec'd by registrar July 4, 1947 Registrar Blas H. PowersMEDICAL CERTIFICATION EDT P20. DATE OF DEATH July 2 1947 at 4:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to acute arsenic poisoning 3 hrs.  
(Arsenic trioxide)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 7/2/47Where did injury occur? Hagerstown Wash. Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Poisoning Injured at work? No

DEPUTY MEDICAL EXAM.

23. SIGNATURE J. Wells WASH. CO., MD.

M. D. or other

Address Hagerstown, Md. Date signed 7/3/47

RECEIVED

JUL 7 1947

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr Ditto

06345

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 13 hours  
 Hospital, institution, or street address where death occurred:  
Wash. Cty. Hospital  
 How long in hospital or institution? 13 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1137 Hamilton Blvd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None.

## 3. (a) FULL NAME

Mrs. Ruth Paxton Conner

## 3. (b) Social Security Number

none

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Lloyd D. Conner  
 7. Birth date of deceased (mo., day, yr.) March 30, 1901  
 6.(c) If alive, give age 47 years  
 8. AGE: Years 46 Months 3 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Houston, Wash. Cty., Pa.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name James M. Paxton

13. Birthplace Houston Pa.

14. Maiden name Mary Russell

15. Birthplace Houston Pa.

18. Informant Lloyd D. Conner

Address Hagerstown, Md.

17. Burial Date thereof July 9, 1947  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Oak Spring Cemetery

Location Canonsburg, Pa.

18. Funeral director Andrew K. Coffman

Address Hagerstown, Md.

19. July 7, 1947 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 6, 1947, at 5:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 5 - 47, to July 6 - 47  
 and that I last saw him alive on July 5, 1947

Immediate cause of death

Cerebral Hemorrhage

DURATION

1 1/2 hrs

Due to

My infarction

Due to

4 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

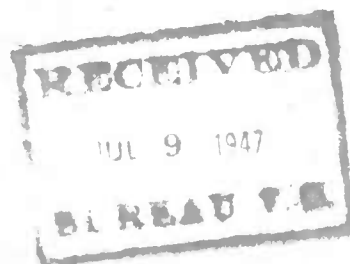
Means of injury Injured at work?

23. SIGNATURE

Edw. Dittus

M. D. or other

Address Hagerstown, Md. Date signed 7/7/47





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

06346

672

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 1/2 days

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 3 1/2 days

## 3. (a) FULL NAME

Baby Girl Crawford

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

6. (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) July 18, 1947 at 7:10 PM

8. AGE: Years Months Days

3 1/2 hrs. min.9. Birthplace Washington County, Maryland  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Frank C. Phillips13. Birthplace Weverton, Maryland14. Maiden name May Crawford15. Birthplace Voyce, Virginia16. Informant Miss May CrawfordAddress Knoxville, Maryland Box 170 ACremation17. (Burial, cremation, or removal, which?) Date thereof July 22, 1947Cemetery or crematory Wash. Co. Hosp. CrematoryLocation Hagerstown, Md18. Funeral director Wash. Co. Hosp.Address Hagerstown, Md19. July 26, 1947 Registrar

Date rec'd by registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Sandy Hook  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 19 47 at 4:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 18 19 47 to July 22 19 47and that I last saw him alive on July 21 19 47

Immediate cause of death

Premature

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE W. L. W. M. D.Address Barnston Date signed 7/24/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
JUL 29 1947  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Ditto

Reg. Dist. No. 302

06347

143

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 week  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 1 week

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 324 North Mulberry St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war none

## 3. (a) FULL NAME

MRS. RACHAEL LOUISE GLADHILL

## 3. (b) Social Security Number

none

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widow  
 6.(b) Name of husband or wife HENRY A.  
 7. Birth date of deceased (mo., day, yr.) May 8, 1860  
 8. AGE: Years 87 Months 1 Days 26 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace HIGHFIELD, WASH. CO. MARYLAND  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business own home

FATHER 12. Name Aaron Wantz  
 13. Birthplace Carlisle, Penn.  
 MOTHER 14. Maiden name Amanda Sterner  
 15. Birthplace Carlisle, Penn.

16. Informant Clarence Brezler  
 Address Hagerstown, Maryland  
 17. burial Date thereof July 7, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetary  
 Location Hagerstown, Maryland  
 18. Funeral director Andrew K. Coffman  
 Address Hagerstown, Maryland

19. July 5, 1947 Registrar Blanch Flowers  
 (Date recd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 4, 1947 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-24-47 19\_\_\_\_, to 7-4-47 19\_\_\_\_

and that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death \_\_\_\_\_

Cerebral Hemorrhage DURATION 3 hrs

Due to \_\_\_\_\_

Due to Sickle ?

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE S. D. Seltzer M. D. or other \_\_\_\_\_Address Hagerstown, Md Date signed 7/5/47

RECEIVED  
JUL 8 1947  
BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

06348

141

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 50 years  
 Hospital, institution, or street address where death occurred:  
Washington County Home  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Washington County Home  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Melchor S. Hager

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower  
 6. (b) Name of husband or wife Margaret A. Hager  
 7. Birth date of deceased (mo., day, yr.) November 25, 1869  
 6. (c) If alive, give age years  
 8. AGE: Years 77 Months 7 Days 6 If less than one day  
 hrs. min.

9. Birthplace Shady Grove, Pa.  
 (Town, county, and state)  
 10. Usual occupation Laborer  
 11. Industry or business  
 12. Name David R. Hager  
 13. Birthplace Shady Grove, Pa.  
 14. Maiden name Panama  
 15. Birthplace Shady Grove, Pa.

16. Informant Daniel S. Hager  
 Address Hagerstown, Maryland  
 17. Burial Date thereof 7-4-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Funkstown Cemetery  
 Location Funkstown, Maryland  
 18. Funeral director C. M. Suter & Sons  
 Address Hagerstown, Maryland  
 19. July 3, 1947 Shady Grove  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st 1947 at 3:30 P.  
 21. CERTIFY that death occurred on the date above stated; that I attended deceased from  
June 24 1947, to July 1 1947  
 and that I last saw him alive on June 28th 1947  
 Immediate cause of death

## DURATION

Cardio-vascular  
renal disease 5 yrs.  
 Due to  
Cerebral Hemorrhage Mar 1947  
Cerebral Hemorrhage 1 wk.  
 Due to  
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE E. J. Fole  
 M. D. or other  
 Address 13820 Washington Date signed 7/2/47



159 *Death*  
4 *307*

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF STILLBIRTH**

Reg. Dist. No. *307*

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

**1. PLACE OF BIRTH:**

County *Washington*  
City or town *Rural*  
(If outside city or town limits, write RURAL and give nearest town)  
Street address, hospital, or institution:  
*Keedysville*  
Length of mother's stay in County *Life*  
(How many years, or months, or days. SPECIFY WHICH)

**2. USUAL RESIDENCE OF MOTHER:**

State *Maryland* *06349*  
County *Washington*  
City or town *Rural*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. *Keedysville*  
(If RURAL give LOCATION)

3. Name of child *Infant Hamilton*

5. Sex *Female* 6. Twin or triplet ☒

4. Date of birth *July 31* 19 *47* Hour *5:30 P.* M.

7. No. of weeks pregnancy *24*

**FATHER OF CHILD**

8. Full name *John Delmas Hamilton*  
9. Color *W* 10. Age at time of this birth *35* yrs.  
11. Usual occupation *Welder*

**MOTHER OF CHILD**

12. Full maiden name *Sda Elizabeth McLean*  
13. Color *W* 14. Age at time of this birth *28* yrs.  
15. Usual occupation *Housewife*

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? *5*  
(b) How many other children were born alive but are now dead? *0* (c) How many other children were born dead? *0*

17. Did child die before labor? *no* During labor? *no*

18. Pregnancy, complications of *Lack of support*

19. Labor: (a) Complications of *Lack of support*

(b) Induced?

20. (a) Was there an operation for delivery? *no*

(b) State all operations, if any (Yes or No)

(c) Did child die before operation?

During operation?

23. (a) *Burial* (b) Date thereof *Aug. 1, 1947*

(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory

24. (a) Funeral director *Buried by John Delmas Hamilton*

(b) Address *Keedysville, Md*

21. Cause of *stillbirth*. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes *Prematurity - mother unable to support weight of fetus*

(b) Maternal causes *Lack of support*

22. I certify to the birth of this child who was born *dead* on the date and hour above stated.

Signature *G. W. Lellan M. D.*

(Specify if M. D., midwife, or other)

Address

25. (a) *Aug. 1, 1947* (b) *Mrs. Lillian D. Gough*

(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)

The above certificate has been examined by me.

Health Officer, per

\* See Instruction C on stub.

Child lived 1 Hr.

I

V. S. 1947

RECEIVED  
MAY 6 1947  
BUREAU V.A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06350 302

1. PLACE OF DEATH:

County Washington  
City or town Frederick  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 5 hours  
Hospital, institution, or street address where death occurred:  
Washington County Hospital  
How long in hospital or institution? 5 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Forest Grove (Rural)  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Rockersville R.I.  
(If rural, give LOCATION)  
2.(a) If veteran, name war Vietnam World War 2

3. (a) FULL NAME

Clifford Martin Haynes

3. (b) Social Security Number

213-12-7214

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.) December - 28 - 1912

8. AGE: Years 34 Months 6 Days 9 If less than one day hrs. min.

9. Birthplace New Rockersville Wash. Co. Md.  
(Town, county, and state)

10. Usual occupation Landscape gardener

11. Industry or business E.A. Stricker Co.

12. Name Harry M. Haynes

13. Birthplace Rockersville Wash. Co. Md.

14. Maiden name Dora E. Eselman

15. Birthplace Carleton Illinois

16. Informant Miss Martha E. Haynes  
Address Rockersville Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof July-9-1947  
(month) (day) (year)  
Cemetery or crematory Forest Grove Cemetery  
Location Forest Grove Md.

18. Funeral director Wm. J. Best & Sons  
Address Boonsboro Md.

19. July 8, 1947 Registrar Phyllis Bowers

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1947 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from EDST. 19... to 19... and that I last saw him alive on 19...

Immediate cause of death

Open fracture of skull DURATION 4 hrs

Due to fracture (left femur)

Due to closed

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7/2/47  
Where did injury occur? Rockersville Wash. Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) on highway

Means of injury Auto overturned Injured at work? No

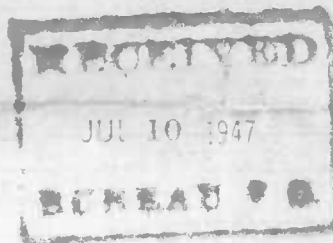
23. SIGNATURE Robert Wells M. D. or other VERITY MEDICAL EXAM  
Address Hagerstown, Md. Date signed 7/8/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Signature for the charge of age is shown on:

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

06351

53

**FILE No. G 110 JUL 17 1947 CERTIFICATE OF DEATH**

Reg. Dist. No. 304

## 1. PLACE OF DEATH:

County Washington  
 City or town Rural Hancock  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 yrs  
 Hospital, institution, or street address where death occurred:  
Route # 2, Hancock  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Rural - Hancock  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Route # 2 - Hancock  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Cora Susan Helser

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife  
 7. Birth date of deceased (mo., day, yr.) Mar. 1, 1878 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 69 Months 65 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace Indian Springs District, Wash. Co., Md.  
 (Town, county, and state)  
 10. Usual occupation None

## 11. Industry or business

12. Name Henry Helser  
 13. Birthplace Indian Springs Dist. Wash. Co., Md.  
 14. Maiden name Margaret Priscilla Zimmerman  
 15. Birthplace Indian Springs Dist. Wash. Co., Md.  
 16. Informant Mrs. J. F. Weller

Address Route # 2 Hancock, Md.  
 17. Burial Date thereof July 6, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Zion Lutheran  
 Location Sylvan, Penna.

18. Funeral director Charles R. Bast  
 Address Hancock Md.

19. 7-3-47 19. J. F. Weller  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 3, 1947 at 7:30 AM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30, 1947 to July 3, 1947  
 and that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death Cerebral hemorrhage  
 DURATION

Due to  
 Due to  
 Other conditions

(Include pregnancy within 3 months of death)  
 Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following.  
 Accident, suicide, or homicide  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Dr. Shaffer  
 Address Hancock Md. Date signed 7/3/47  
 M. D. or other

COPY SENT TO County LOCAL REGISTRAR No. \_\_\_\_\_ DATE 7/7/47

RECEIVED  
JUL 7 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING  
I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. <sup>the correct age</sup> is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 172

## CERTIFICATE OF DEATH

66490  
Reg. Dist. No. 307

### 1. PLACE OF DEATH:

County... Washington County  
City or town... Near Harpers Ferry, W. Va.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

Daniel Webster Hendricks 3rd

Dan Hendricks

### 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife Margaret Polhamus

6. (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) October 11th 1913.

8. AGE: Years Months Days If less than one day  
33 9 18 ..... hrs. .... min.

9. Birthplace Uvilla, West Virginia.  
(Town, county, and state)

10. Usual occupation Merchant

11. Industry or business General Merchandise

12. Name Daniel Webster Hendricks 2nd

13. Birthplace Uvilla, W. Va.

14. Maiden name Sarah Virginia Link

15. Birthplace Duffields, W. Va.

16. Informant Gilbert L. Hendricks

Address R.F.D. Shenandoah Junction

17. Burial Date thereof Aug. 2nd 1947  
(Burial, ~~cremation~~, or ~~other~~) (month) (day) (year)

Cemetery or ~~other~~ Elmwood

Location Shepherdstown, W. Va.

18. Funeral director Melvin T. Stender

Address Charles Town, W. Va.

19. Aug. 6. 19 47  
(Date rec'd by registrar)

Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... W. Va. County... Jefferson

City or town... Shenandoah Junction.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....  
(If rural, give LOCATION)

2. (a) If veteran, name war

### MEDICAL CERTIFICATION

EDT

20. DATE OF DEATH July 29 19 47 at 10:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

DURATION

Due to Suffocation by drowning

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident July 29 '47

Accident, suicide, or homicide Date of  
Where did injury occur? R.F.D. Harpers Ferry, Jefferson W. Va.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Potomac River

Means of injury Fell out of out-house into pool Injured at work

DEPUTY MEDICAL EXAM.

WALL CO. MD.

23. SIGNATURE J. Robert Wells M. D. examiner

Address Harpers Ferry, Md. Date signed July 31 '47

RECEIVED

AUG 20 1947

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06352

52

Reg. Dist. No. 304

## 1. PLACE OF DEATH:

County WashingtonCity or town Hancock  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifeHospital, institution, or street address where death occurred:  
Main StreetHow long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hancock  
(If outside city or town limits, write RURAL and give nearest town)Street No. Main Street  
(If rural, give LOCATION)2.(a) If veteran, name war —

## 3. (a) FULL NAME

Cora Anna Smith Huber4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife George C. Huber7. Birth date of deceased (mo., day, yr.) Nov. 16, 18736.(c) If alive, give age — years8. AGE: Years 73 Months 8 Days 17 If less than one day — hrs. — min.9. Birthplace Hancock Wash. Co., Md.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business —12. Name James R. Smith13. Birthplace Pennsylvania14. Maiden name Mariah A. Dawson15. Birthplace West Virginia16. Informant Mrs. Oscar RashAddress Main St., Hancock, Md.17. Burial Date thereof July 5, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Thomas EpiscopalLocation Hancock, Md.18. Funeral director Charles R. BastAddress Hancock, Md.19. 7-3-47 19 —  
(Date rec'd by registrar)Registrar J. P. Heller

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

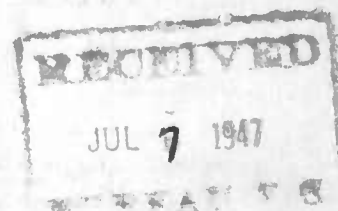
20. DATE OF DEATH July 2, 1947 at 10:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1947 to July 2, 1947and that I last saw him alive on July 2, 1947Immediate cause of death Chronic myocarditis

DURATION

Due to —Due to —Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —Autopsy results —  
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) — (County) — (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE J. M. Schaffer M.D.  
M. D. or other —Address Hancock, Md. Date signed 7/8/47



COPY SENT TO LOCAL REGISTRAR NO. County DATE 7/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

128

06353

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? life  
Hospital, institution, or street address where death occurred:  
Washington County Hospital  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 131 Mc Comas St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

William Henry Jacobs

3. (b) Social Security Number

214-09-1022

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
6.(b) Name of husband or wife Mary E. Jacobs  
7. Birth date of deceased (mo., day, yr.) Sept, 17, 1874 6.(c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 72 75 Months 10 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Hagerstown, Wash. Co. Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Isaac Jacobs  
13. Birthplace Washington Co. Md.  
14. Maiden name Mary Longnecker  
15. Birthplace Washington Co. Md.

16. Informant Mrs. Mary E. Roffenberger  
Address 131 Mc Comas St. City

17. Burial Date thereof July 24, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Rose Hill Cemetery  
Location Hagerstown, Maryland

18. Funeral director Fred W. Kraiss  
Address Hagerstown, Md.

19. July 24, 1947 Registrar Phyllis Bowers  
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21, 1947 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 1947, to July 21 1947  
and that I last saw him alive on July 21 1947

Immediate cause of death Acute Pancreatitis DURATION 6 wks

Due to

Due to

Other conditions Uremia 2 wks

(Include pregnancy within 3 months of death)

Major findings of operations

Acute Pancreatitis Date of op. \_\_\_\_\_  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Phyllis Bowers M. D. or notary \_\_\_\_\_

Address 157 W. Washington St. Date signed 7/23/47

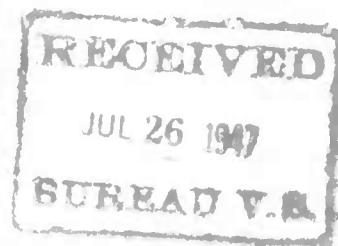
MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 06354 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 54 years  
 Hospital, institution, or street address where death occurred:  
Washington County Home  
 How long in hospital or institution? 15 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Wilbur A. Keller

## 3. (b) Social Security Number

220-18-1193

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) May 21, 1882  
 8. AGE: Years 65 Months 1 Days 27 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Middletown, Maryland  
 (Town, county, and state)  
 10. Usual occupation Tailor  
 11. Industry or business \_\_\_\_\_

12. Name Charles W. Keller  
 13. Birthplace Middletown, Maryland  
 14. Maiden name Sarah E. Cookerly  
 15. Birthplace Middletown, Maryland

16. Informant Miss Ruth Keller  
 Address Hagerstown, Maryland

17. Burial Date thereof 7-20-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons  
 Address Hagerstown, Maryland

19. July 19 19 47 B. H. H. Bowen  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 19 47 at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on July 15 19 47  
 Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Chr. myocardial heart disease ?Due to mitral insufficiencyDue to acute ventricular fibrillation

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. \_\_\_\_\_

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE S. P. H. H. Bowen M. D. or \_\_\_\_\_Address Hagerstown, Md Date signed 2/19/47

MARGIN RESERVED FOR BINDING

VS A15

9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 22 1991  
BUREAU F B I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

53b

06355

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington  
City or town Hagerstown, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 50 years  
Hospital, institution, or street address where death occurred:  
Washington County Hospital  
How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1119 Virginia Avenue  
(If rural, give LOCATION)  
2. (a) If veteran, name war.

3. (a) FULL NAME

Annie Elizabeth King

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Isaac King

6. (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) January 12, 1874

8. AGE: Years 73 Months 6 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Cumberland, Maryland  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John Wiebel

13. Birthplace Cumberland, Maryland

14. Maiden name Elizabeth Schmidt

15. Birthplace Germany

16. Informant Isaac King

Address Hagerstown, Maryland

17. Burial Date thereof 7-24-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. July 23, 1947 Registrar Phost/Bowers

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21, 1947 at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 28, 1947 to July 21, 1947 and that I last saw him alive on July 21, 1947

Immediate cause of death Squamous cell carcinoma  
Right lower lobe

Due to Carcinoma of lung

Due to Acute myocarditis

Other conditions Chenysted arthritis

Multiple

(Include pregnancy within 3 months of death)

Major findings of operation Squamous cell carcinoma

Rt. lobe resected Date of op 2-18-47

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide X Date of X

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE W. Howard George

Address Hagerstown, Md M. D. or other July 22, 47

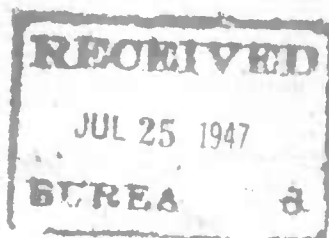
Date signed

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

06356

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 weeks  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 2 weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penna County Franklin  
 City or town Greencastle  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 49 So. Carlisle St.  
 (If rural, give LOCATION)  
None  
 2.(a) If veteran, name war ☒

## 3. (a) FULL NAME

Fred. L. Kuhn

## 3. (b) Social Security Number

162-22-2108

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife --  
 7. Birth date of deceased (mo., day, yr.) January 13 1883  
 8. AGE: Years 64 Months 6 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Greencastle Franklin Co. Pa.  
 (Town, county, and state)  
 10. Usual occupation Machinist  
 11. Industry or business Leiter & Kuhn Imp. Co.  
 12. Name Samuel F. Kuhn  
 13. Birthplace Greencastle Pa.  
 14. Maiden name Margaret P. Leshner  
 15. Birthplace Waynesboro Pa.

16. Informant Estella Kuhn  
 Address Greencastle Pa.  
 17. Burial Date thereof 7/28/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Cedar Hill Cemetery  
 Location near Greencastle Pa.  
 18. Funeral director A.E. Minnich  
 Address Greencastle Pa.

19. July 26. 47 Registrar Chas. Flowers  
 (Date recd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1947 19\_\_\_\_ at 7.40 A  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/8 1947 to 7/25 1947  
 and that I last saw him live alive on 7/25 1947

## Immediate cause of death

heated hypertrophic gastritis +  
Enterocolitis

## DURATION

6 mo. (?)

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results Same as above (no Ca or Tbc)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John Hornbaker M.D. or otherAddress 154 W. Washington St. Date signed 7/26/47

MARGIN RESERVED FOR BINDING

VS A16 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 29 1947  
BUREAU V.R.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Ditto

152

06357  
302

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown R#4  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 40 Years  
 Hospital, institution, or street address where death occurred:  
Cearfoss Pike  
 How long in hospital or institution? --

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown R#4  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Cearfoss Pike  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

DAVID LESHER LONG

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Married

## 6.(b) Name of husband or wife

Clara Etta Long6.(c) If alive, give age 76 years

## 7. Birth date of deceased (mo., day, yr.)

May 29, 1871

## 8. AGE:

Years

Months

Days

If less than one day

76117

hrs.

min.

## 9. Birthplace

Downsville, Washington Co., Md.  
(Town, county, and state)

## 10. Usual occupation

Farmer

## 11. Industry or business

RetiredFATHER  
MOTHER

## 12. Name

Joseph Rowland Long

## 13. Birthplace

Fairplay Md.

## 14. Maiden name

Elizabeth Leshar

## 15. Birthplace

Clearspring Md.

## 16. Informant

Kenneth Long

## Address

Hagerstown Md. R#4

## 17.

Burial

Date thereof

7/18/47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

Rest Haven Cemetery

## Location

Hagerstown Md.

## 18. Funeral director

Andrew K. Coffman

## Address

Hagerstown

## 19.

July 17, 1947  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 19 47 at 7:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 17-46 19 46 to July 16-47 19 47  
and that I last saw him alive on July 16-47

Immediate cause of death

DURATION

Due to

Arterio Scl7/17/46

Due to

Cardio-Renal System2 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

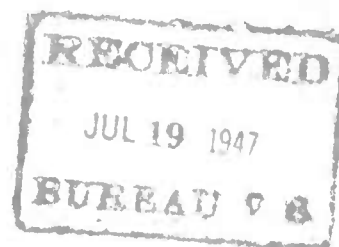
23. SIGNATURE

M. D. or other

Address

Date signed





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Conrad

06358

Reg. Dist. No. 308

## 1. PLACE OF DEATH:

County Washington  
 City or town Brethedsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 Months  
 Hospital, institution, or street address where death occurred:  
Md. State Reformatory for Males  
 How long in hospital or institution? 10 Months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 650 W. Fairmount  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None ✓

## 3. (a) FULL NAME

GROVER LOVE

## 3. (b) Social Security Number

Unable to locate

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Divorced  
 6. (b) Name of husband or wife --  
 7. Birth date of deceased (mo., day, yr.) March 23, 1909  
 8. AGE: Years 38 Months 3 Days 20 If less than one day hrs. min.

9. Birthplace Concord, Cabarrus Co., N. Carolina  
 (Town, county, and state)

10. Usual occupation Laborer

## 11. Industry or business

12. Name Charles Love  
 13. Birthplace Concord N. C.  
 14. Maiden name Malinda Polk  
 15. Birthplace Concord N. C.

16. Informant Files Md. St. Refmtry. Males  
 Address Brethedsville Md.

17. Burial Date thereof July 18, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory City Cemetery  
 Location Charlotte City, N. C.

18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. July 15, 1947 John H. Bass  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 13, 1947 at 11:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4:30 PM Nov. 4, 1946, to July 13, 1947  
 and that I last saw him alive on July 13, 1947

Immediate cause of death

Pulm. Tuberculosis

DURATION

2 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert P. Conrad, M.D.

Hagerstown, Md. M. D. or other 7-14-47

Address Date signed

RECEIVED  
JUL 19 1947  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Lusby

06359

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 19 Years  
 Hospital, institution, or street address where death occurred:  
14 Glenside Ave.  
 How long in hospital or institution? 19 Years

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 14 Glenside Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

MRS MARY LUCRETIA LUTHER

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow  
 6.(b) Name of husband or wife George W.  
 8.(c) If alive, give age -- years  
 7. Birth date of deceased (mo., day, yr.) November 20 1863  
 8. AGE: Years 83 Months 6 Days 29 If less than one day hrs. min.

9. Birthplace Beaver Creek, Washington Co., Md.  
 (Town, county, and state)

10. Usual occupation Housewife11. Industry or business Own Home

12. Name Jacob S. Huyett  
 13. Birthplace Beaver Creek Md.

14. Maiden name Lucretia Hildebrand  
 15. Birthplace Beaver Creek Md.

16. Informant Mr. Frank Luther  
 Address Hagerstown Md.

17. Burial Rose Hill Cemetery Date thereof 7/21/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. July 20. 19 47 Blair Howard  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 19 47 at 10:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 19 47, to 19 July 19 47  
 and that I last saw him alive on 1 P. July 19 47

Immediate cause of death arterio sclerotic Cardio vascular Disease DURATION 10 yrs +

Due to arterio sclerotic Cardio vascular Disease

Due to arterio sclerotic Cardio vascular Disease

Other conditions arterio sclerotic Cardio vascular Disease

(Include pregnancy within 3 months of death)

Major findings of operations arterio sclerotic Cardio vascular Disease

Date of op. arterio sclerotic Cardio vascular Disease

Autopsy results arterio sclerotic Cardio vascular Disease

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide arterio sclerotic Cardio vascular Disease Date of July 19, 1947

Where did injury occur? arterio sclerotic Cardio vascular Disease (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) arterio sclerotic Cardio vascular Disease

Means of injury arterio sclerotic Cardio vascular Disease Injured at work? arterio sclerotic Cardio vascular Disease

23. SIGNATURE J. J. Lusby M. D. or other July 20, 1947  
 Address 2301 Potomac Date signed July 20, 1947

RECEIVED  
JUL 22 1947  
BUREAU

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

no birth required

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore 165  
CERTIFICATE OF DEATH

182  
6495

Reg. Dist. No. 302

1. PLACE OF DEATH:  
County Washington  
City or town Washington County Hospital  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Found in bushes behind filling station at east end of Hancock, Md.  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME Unknown Male Child M-Carty  
3. (b) Social Security Number

4. Sex Female  
5. Color or race White  
6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....  
6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr) 1947  
8. AGE: Years Months Days If less than one day  
7 hrs. min.

9. Birthplace.....  
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER  
12. Name Gerald J. Montgomer  
13. Birthplace Needmore, Pa.  
MOTHER  
14. Maiden name Dorothy M-Carty  
15. Birthplace Hancock, Ind.

16. Informant.....  
Address.....

17. Burial Date thereof August 8, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Bellevue Cemetery  
Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss  
Address Hagerstown, Md.

19. Aug. 5, 1947 Charles Bowers  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION  
Between July 31, '47 and Aug. 1, '47  
20. DATE OF DEATH July 30, 1947 at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....  
and that I last saw him alive on.....

Immediate cause of death.....  
suffocation by strangulation

Due to umbilical cord was wrapped around neck 6 times  
Due to..... [9/10/47 ahs]

Other conditions.....  
(Include pregnancy within 3 months of death)

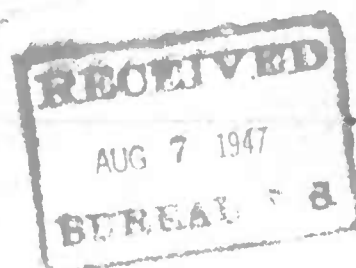
Major findings of operations.....  
Date of op.....

Autopsy result as above Aug 2/47  
PHYSICIAN: Please underline the cause to which death should be charged anatomically.

22. VIOLENCE: If death was due to external causes, fill in the following: Strangled  
Accident, suicide, or homicide Strangled Date of Aug. 1st  
Where did injury occur? Unknown  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Unknown  
Means of injury Strangled Injured at work? No

23. SIGNATURE S. Robert Wells DEPUTY MEDICAL EXAM.  
Address Hagerstown, Md. WASH. CO., MD.  
Date signed 8/4/47



Evidence for the change of  
age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Ditto

FILM No. G 111 AUG 1-1947 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington  
City or town Hagerstown R# 1  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 43 Years  
Hospital, institution, or street address where death occurred:  
Beaver Creek  
How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington  
City or town Hagerstown R# 1  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Beaver Creek  
(If rural, give LOCATION)  
2. (a) If veteran, name war None

3. (a) FULL NAME

MRS EMMA ROBERTS MCCAULEY

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Harvey

7. Birth date of deceased (mo., day, yr.) November 13, 1873

8. AGE: Years 74 Months 8 Days 3 If less than one day hrs. min.

9. Birthplace Hagerstown, Washington Co., Md  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name John H. Hebb

13. Birthplace Sharpsburg Md.

14. Maiden name Mary Seiss

15. Birthplace Sharpsburg Md.

16. Informant Mrs Catherine Hoover  
Address Williamsport Md.

17. Burial Christian Church Cemetery Date thereof 7/18/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Christian Church Cemetery

Location Beaver Creek Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. July 17, 1947 John H. Bast  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 19 47, at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-14-47 to 7-16-47 and that I last saw him alive on 7-15-47

Immediate cause of death Cerebral Hemorrhage

DURATION

6 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Ditto M. D. or other

Address Hagerstown Date signed 7/18/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 302

## 1. PLACE OF DEATH

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital  
13 days

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 755 Guilford

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Evia Miller

## 3. (b) Social Security Number

-----

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Guy W. Miller

7. Birth date of

deceased (mo., day, yr.)

March 24 18906. (c) If alive, give age 57 years

8. AGE:

57

Years

Months

3

Days

26

If less than one day

hrs.

min.

9. Birthplace

Funkstown Wash. Md.

(Town, county, and state)

10. Usual occupation

House Wife

11. Industry or business

Own Home

FATHER

12. Name

Frank K. Williams

13. Birthplace

Funkstown Md.

MOTHER

14. Maiden name

Ann Rodenhizer

15. Birthplace

Funkstown Md.

16. Informant

Guy W. Miller

Address

Hagerstown Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 7-22-47

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown Md.

18. Funeral director

Scott F. Minnich & Son

Address

Hagerstown Md.

19.

(Date rec'd by registrar)

July 22, 47

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

7-20-47 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7-8-47 to 7-20-47

and that I last saw her alive on

7-20-47

Immediate cause of death

Acute coronary occlusion

DURATION

2 wks (?)

Due to

Due to

Other conditions

Thrombotic occlusion  
Left popliteal  
arterial thrombosis  
6 days

4 yrs  
12 days  
27 days

Major findings of operations

Date of op.

Autopsy results

See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John H. Humber  
154 W. Washington St.  
Hagerstown, Md.  
 Date signed 7/21/47

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 24 1947  
BUREAU 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Lusby

06362

170

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5½ Months  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 5½ Months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 220 E. Antietam St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

Miss Florence Caroline Miller

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife ---  
 7. Birth date of deceased (mo., day, yr.) August 23, 1879  
 8. AGE: Years 67 Months 11 Days 1 It less than one day hrs. min.

9. Birthplace Rocky Ridge, Fredrick Co., Md.  
 (Town, county, and state)

10. Usual occupation Private Nurse

## 11. Industry or business

12. Name William F. Miller

13. Birthplace Marion Pa.

14. Maiden name Julia Heiner

15. Birthplace Rocky Ridge Md.

16. Informant Mrs. Sara Hoke

Address Emmitsburg Md.

17. Burial Date thereof 7/26/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Tabor Lutheran Cemetery

Location Rocky Ridge Md.

18. Funeral director Andrew K. Coffran

Address Hagerstown Md.

July 26, 19 47 Charles Boward  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 19 47 at 1:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 Nov 19 46 to 24 July 19 47  
 and that I last saw her alive on 23 July 19 47

Immediate cause of death Chronic Nephritis DURATION 10 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. J. Lusby M. D. or other

Address 2307 R. Times Date signed 25 July 47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Wash. County HospitalHow long in hospital or institution? 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Rural Hancock, Md. R D 2  
(If outside city or town limits, write RURAL and give nearest town)Street No. Millstone Dist.  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Bruce James Mills Sr.

## 3. (b) Social Security Number

220-09-9193

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Lulu Irene Mills

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of deceased (mo., day, yr.)

April 17, 1898

## 8. AGE:

Years 49Months 2Days 20

If less than one day

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 9. Birthplace

Washington County, Md.

(Town, county, and state)

## 10. Usual occupation

Employee of

## 11. Industry or business

Auto Salvage Co.

## 12. Name

John H. Mills

## 13. Birthplace

Washington County, Md.

## 14. Maiden name

Ella Bridendolph

## 15. Birthplace

Washington County, Md.

## 16. Informant

Mrs. Lulu I. Mills

## Address

Hancock, Md. R D 2

## 17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof July 10, 1948  
(month) (day) (year)

## Cemetery or crematory

Stone Bridge Cemetery

## Location

Hancock, Md. Rural

## 18. Funeral director

Snyder-Rowland

## Address

Hancock, Md.

## 19.

(Date rec'd by registrar)

July 9, 1948

Registrar

## MEDICAL CERTIFICATION

D.S.T.20. DATE OF DEATH July 7, 1947 10:20 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

JUNE 17, 1947 to JULY 7, 1947and that I last saw him alive on JULY 7, 1947

Immediate cause of death

CEREBRAL ACCIDENTSITE UNDETERMINEDDue to HYPERTENSIVE CARDIOVASCULAR DISEASE

Other conditions

Bronchitis, chronicBronchial asthma

(Include pregnancy within 3 months of death)

Major findings of operations

None.

Date of op.

Autopsy results

None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

Pauli Robert Cohen  
Clea Spring Md  
M. D. \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 7-9-47

RECEIVED

JUL 11 1947

BUREAU V A

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06364

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 22 years

Hospital, institution, or street address where death occurred:

228 Winter Street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 228 Winter Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Cassie Mort

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Issac Mort

8. (c) If alive, give age years

## 7. Birth date of deceased (mo., day, yr.)

July 30, 1857

## 8. AGE:

Years

89

Months

11

Days

2

If less than one day

hrs.

min.

9. Birthplace Centerville, Washington, Penna.  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

Housekeeping

## MOTHER

## FATHER

12. Name Thomas Horton13. Birthplace Washington county, Penna.14. Maiden name Mary Rogers15. Birthplace Washington county, Penna.

## 16. Informant

Mr. Ernest HighbergerAddress 232 Winter St. Hagerstown, Md.17. Burial  
(Burial, cremation, or removal, Which?)Date thereof July 4, 1947  
(month) (day) (year)Cemetery or crematory Mountain View CemeteryLocation Sharpsburg, Maryland

## 18. Funeral director

Mrs. Edith V. LeafAddress Williamsport, Maryland19. July 3, 1947  
(Date rec'd by registrar)Charles Howard  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 19 47 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/2/47 19 47 to 7/2/47 19 47  
and that I last saw him alive on 7/2/47 19 47

Immediate cause of death

cerebral infarction

DURATION

2 Days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

C. Howard  
M. D. or other  
Address Williamsport, Md. Date signed 7/3/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JUL 5 1947

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Ditto

66491

93d

Reg. Dist. No. 303

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown R #2  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 Months  
 Hospital, institution, or street address where death occurred:  
Huyetts  
 How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown R#2  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Huyetts Crossroads  
 (If rural, give LOCATION)  
None  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

MRS ANNIE VICTORIA MYERS

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Harvey A. Myers  
 6.(c) If alive, give age -- years  
 7. Birth date of deceased (mo., day, yr.) Sept. 11, 1870  
 8. AGE: Years 76 Months 9 Days 21 If less than one day -- hrs. -- min.  
 9. Birthplace Greencastle, Franklin Co., Pa.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Own Home  
 12. Name Rev. William W. Wolf  
 13. Birthplace Mt. Tabor Md.  
 14. Maiden name Lydia Summers  
 15. Birthplace Huyetts Md.

16. Informant Walter A. Myers  
 Address Hagerstown R # 2  
 17. Burial Date thereof 7/5/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Dunkard Cemetery  
 Location Bradfording Md.  
 18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.  
 19. July 3 19 47 Low McSeth  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 19 47 8:15P M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 - 47 to July 2 - 47  
 and that I last saw him alive on June 30 - 47 19 47  
 Immediate cause of death Chc. Myocarditis  
arteriosclerosis

## DURATION

Due to Chc. Myocarditis  
arteriosclerosis  
 Due to Chc. Myocarditis  
arteriosclerosis  
 Other conditions Chc. Myocarditis  
arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations Chc. Myocarditis  
arteriosclerosis  
 Date of op. 7/5/47

Autopsy results Chc. Myocarditis  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide Chc. Myocarditis Date of 7/5/47  
 Where did injury occur? Chc. Myocarditis (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) Chc. Myocarditis  
 Means of injury Chc. Myocarditis Injured at work? Chc. Myocarditis

23. SIGNATURE Dr. Ditto M. D. or other Dr. Ditto  
 Address Hagerstown Md. Date signed 7/5/47

RECEIVED

SEP 4 1947

BUREAU # 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06365 174

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... WashingtonCity or town... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 weeks

Hospital, institution, or street address where death occurred:

241 - South Locust St.How long in hospital or institution? at home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Mt. Green - (Rural)  
(If outside city or town limits, write RURAL and give nearest town)Street No. Kidzville Rd. R. 1.  
(If rural, give LOCATION)2(a) If veteran, name war... none

## 3. (a) FULL NAME

James William Nave

## 3. (b) Social Security Number

none

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Susan Crider

## 7. Birth date of deceased (mo., day, yr.)

July - 16 - 1878

## 6. (c) If alive, give age

years

## 8. AGE:

Years 69 Months 0 Days 11 If less than one day

hrs. min.

## 9. Birthplace

Williamsport Wash. Co. Md.  
(Town, county and state)

## 10. Usual occupation

Retired Railroader

## 11. Industry or business

Retired Railroader

## FATHER

12. Name... Joseph Nave13. Birthplace... England

## MOTHER

14. Maiden name... Mattie Roof15. Birthplace... Indian Springs Md.16. Informant... Jacob R. NaveAddress 241 S. Locust St. Hagerstown Md.17. Burial Date thereof July 29, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Boonshus CemeteryLocation... Boonshus Md.18. Funeral director... Wm J. Bair & SonsAddress Boonshus Md.19. July 28, 47 Boonshus  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... July - 27 - 1947, at 5:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 6 1947 to July 27 1947and that I last saw h. a. alive on July 27 1947

## Immediate cause of death

Cerebral A. embolism

## DURATION

2 wksDue to... Cardio VascularDue to... StrokeDue to... StrokeDue to... StrokeDue to... StrokeDue to... StrokeDue to... StrokeDue to... StrokeDue to... StrokeDue to... StrokeDue to... StrokeDue to... StrokeDue to... StrokeDue to... StrokeDue to... StrokeDue to... StrokeDue to... StrokeDue to... Stroke23. SIGNATURE... Eldon E. H. ...

M. D. or other

Address... 115 W. Washington St. Date signed 28 July 47Address... Hagerstown Md.

RECEIVED  
JUL 30 1967  
BUREAU V.R.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06366

158

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

71 1/2 East Antietam Street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 71 1/2 East Antietam St.

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Evelyn May Negley

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Robert Preston Negley

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) May 5, 1913

8. AGE: Years Months Days If less than one day

34211

hrs. min.

9. Birthplace Washington County Maryland

(Town, county, and state)

10. Usual occupation Home Duties

11. Industry or business

12. Name Isaac Trumpower13. Birthplace Maryland14. Maiden name Bessie Hose15. Birthplace Maryland16. Informant Robert Preston NegleyAddress 71 1/2 E. Antietam St. Hagerstown, Md.17. Burial Date thereof July 18, 1947

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rest Haven CemeteryLocation Hagerstown, Maryland18. Funeral director Fred W. KraissAddress Hagerstown, Maryland19. July 18, 1947 Chas. Bowers

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION EDT

20. DATE OF DEATH July 16, 1947 19 47 at 2:30 A M21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 45 to July 15, 1947and that I last saw her alive on July 15, 1947Immediate cause of death Carcinoma of cervix DURATION May '46

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. Robert Wells M.D.Address Hagerstown, Md. Date signed 7/17/47

RECEIVED  
JUL 21 1947  
BUREAU OF A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 06367 301

## 1. PLACE OF DEATH:

County Washington County  
 City or town Williamsport, Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 45 yrs  
 Hospital, institution, or street address where death occurred:  
28 E Frederick St.  
 How long in hospital or institution? 45 yrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Williamsport,  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 28 E Frederick St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

Geroge Lester Newcomer

## 3. (b) Social Security Number

214.16-0739

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Lena Robinson Newcomer  
deceased 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Oct. 10 1864  
 8. AGE: Years 62 Months 8 Days 24 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Williamsport, Md  
 (Town, county, and state)  
 10. Usual occupation Painter & Paper Hanger  
 11. Industry or business Painting & Papering  
 FATHER 12. Name Henry Z Newcomer  
 13. Birthplace Fairview Mt. Md.  
 MOTHER 14. Maiden name Emma Ardinger  
 15. Birthplace Williamsport Md  
 16. Informant Mr. Grayson Newcomer  
 Address Williamsport, Md.

17. Burial Date thereof July 7 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Greenlawn Cemetery  
 Location Williamsport, Md  
 18. Funeral director Edith V Leaf  
 Address #7 Church St. Williamsport, Md.

19. 7/7 19 47 E Lee McElroy  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 19 47 at 4:20 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 47 to July 4 19 47  
 and that I last saw him alive on July 30 19 47

Immediate cause of death Carcinoma of lungs DURATION 6 mos

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

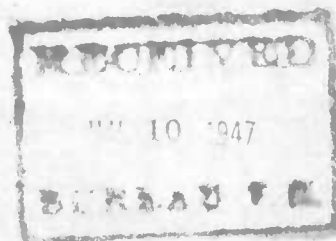
Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE E Lee McElroy M. D. or other \_\_\_\_\_  
 Address Williamsport Md Date signed 7/5/47





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

06368

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? life  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 3 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 835 Oak Hill Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Edward Oswald

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 8.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Mary Shade Oswald  
 6.(c) If alive, give age 75 years  
 7. Birth date of deceased (mo., day, yr.) February 1, 1866  
 8. AGE: Years 81 Months 5 Days 25 If less than one day  
 .....hrs. ....min.

9. Birthplace Hagerstown, Wash. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Clerk of Court  
 11. Industry or business

FATHER 12. Name George B. Oswald  
 13. Birthplace Cavetown, Wash. Co. Md.  
 MOTHER 14. Maiden name Mary E. Gumbert  
 15. Birthplace Hagerstown, Maryland

16. Informant Edward Oswald, Jr.  
 Address Hagerstown, Maryland

17. Burial Date thereof 7-29-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons  
 Address Hagerstown, Maryland

19. July 29, 1947 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 19 47 at 12:30 P.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
June 17 19 47 to July 26 19 47  
 and that I last saw him alive on July 26 19 47

Immediate cause of death Cardiac dilatation  
 DURATION 7/25/47

Due to myocarditis chr ?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hh Porterfield M.D. M. D. or other  
 Address 136 W Washington Date signed 7/28/47

MARGIN RESERVED FOR BINDING

I

9.45.15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 31 1947

BURH A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

153

## CERTIFICATE OF DEATH

Dr. Layman

06492

Reg. Dist. No. 303

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown R # 2  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 months  
 Hospital, institution, or street address where death occurred:  
Layman Nursing Home  
 How long in hospital or institution? 5 Mos.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 498 North Potomac St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

MRS LEILA FIERY OSWALD

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow  
 6. (b) Name of husband or wife George B.  
 7. Birth date of deceased (mo., day, yr.) March 6 1867  
 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 80 Months 4 Days 22 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Hagerstown Wash. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Own Home

FATHER 12. Name Joseph H. Fiery  
 13. Birthplace Fairview Md.  
 MOTHER 14. Maiden name Mary Ridenour  
 15. Birthplace Hagerstown Md.

16. Informant Miss Helen Heard  
 Address Hagerstown Md.

17. Burial Burial Date thereof 7/31/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. Feb 29 19 47 Lois M. Lark  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1947 19\_\_\_\_ at 11 P  
 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
September 19 46, to 28 July 19 47  
 and that I last saw him alive on 28 July 19 47

Immediate cause of death Senility  
 DURATION 1 year

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Arteriosclerosis Diabetes  
(decubitus) (ulcers)  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. J. Layman M.D.

Address 101 Cromwell Ct Bldg 29 July 47  
Hagerstown, Md. Date signed \_\_\_\_\_

RECEIVED

SEP 4 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

06369

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 1/2 years  
Hospital, institution, or street address where death occurred:  
73 Madison Ave.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 73 Madison Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

David W. Reed

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Myrtle Reed

7. Birth date of deceased (mo., day, year) March 19, 1869 6.(c) If alive, give age years

8. AGE: Years 78 Months 4 Days 6 It less than one day hrs. min.

9. Birthplace Big Poole, Wash. Co. Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Reed

13. Birthplace

14. Maiden name Unknown

15. Birthplace

16. Informant Mrs. Ida Cassidy

Address 73 Madison Ave. Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof July 28, 1947  
(month) (day) (year)

Cemetery or crematory Park Head Cemetery

Location Near Hancock, Maryland

18. Funeral director Snyder-Rowland

Address Hancock, Maryland.

19. July 28, 47 Geoff Bowers  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1947 19 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/13/47 to 7/25 and that I last saw him alive on 7/25

Immediate cause of death Coronary occlusion DURATION 2 weeks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert L. Young M.D. M. D. or other

Address Wellington, Md. Date signed 7/26/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED  
JUL 30 1947  
BUREAU V-R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Conrad

1.55

06370

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 days  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 12 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 104 Greenmount Ave  
 (If rural, give LOCATION)  
 2(a) If veteran, name war None

## 3. (a) FULL NAME

MRS KATHERINE DELANNAH RICE

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Arthur Lee  
 6. (c) If alive, give age 46 years  
 7. Birth date of deceased (mo., day, yr.) June 23 1905  
 8. AGE: Years 42 Months 0 Days 21 If less than one day  
 hrs. min.

9. Birthplace Myersville Fred. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Own Home  
 12. Name John Henry Gorine  
 13. Birthplace Gadsden Tenn.  
 14. Maiden name Lugenia M. Harp  
 15. Birthplace Myersville Md.

16. Informant Arthur Lee Rice  
 Address Hagerstown Md.  
 17. Burial Date thereof 7/17/47  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Mt. Zion Evan. U.B. Cemetery  
 Location Myersville Md.  
 18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.  
 19. July 15, 1947  
 (Date read by registrar)

## MEDICAL CERTIFICATION

Noon

20. DATE OF DEATH July 14 1947 19 47 at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 14 1947  
 and that I last saw him alive on July 14 1947

Immediate cause of death Sub-arachnoid hemorrhage DURATION 14 days

Due to Hypertension 1 yr.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert P. Conrad M.D. M. D. or other

Address Hagerstown, Md Date signed 7-14-47

Registrar



RECEIVED

JUL 17 1947

SECRET & B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06371-302  
Reg. Dist. No.

1. PLACE OF DEATH: Washington  
County.....  
City or town..... Hagerstown Rural R.D. 1  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 6 years Cavetown Pike  
Hospital, institution, or street address where death occurred:  
Residence Hagerstown R.D. 1  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Maryland County..... Washington  
City or town..... Hagerstown Rural R.D. 1  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... Cavetown Pike  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME Ralph Raymond Ruck

3. (b) Social Security Number  
217-09-9848

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Elsie E. Ruck  
7. Birth date of deceased (mo., day, yr.) Feby. 12, 1905  
6. (c) If alive, give age..... years  
8. AGE: 42 Years 4 Months 25 Days It less than one day  
hrs. min.

9. Birthplace Hagerstown- Wash. Co., Md.  
(Town, county, and state)  
10. Usual occupation Steward  
11. Industry or business N. Am. Rod and Gun Club

12. Name Samuel Ruck  
13. Birthplace W. Virginia  
14. Maiden name Mary Lloyd  
15. Birthplace Hagerstown, Md.

16. Informant Mrs. Elsie Ruck  
Address Hagerstown, Md. R D 1

17. Burial Date thereof July 10, 1947  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Broadfording Cemetery  
Location Near Cearfoss, Md.

18. Funeral director Fred W. Kraiss  
Address Hagerstown, Md.

19. July 9, 1947  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1947 19..... al..... A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
1942 19..... to July 7 1947  
and that I last saw him alive on July 7 1947  
Immediate cause of death Carcinoma with metastases  
DURATION 1 yr.  
Due to Carcinoma - rectal 5 yrs.  
Due to.....  
Other conditions.....

(Include pregnancy within 3 months of death)  
Major findings of operations Carcinoma of rectum +  
seminoma of testicle Date of op. 1942 + 1947  
Autopsy results N.R.  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Lloyd A. Hoffman  
M. D. or other  
Address 214 N. Potomac St. Date signed July 8, 1947

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 11 1947

BUREAU OF A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Wells

06372

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Security  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 Hours  
 Hospital, institution, or street address where death occurred:  
North Amer. Cement Corp.  
 How long in hospital or institution? 7 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 28 Summer St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

JOSEPH ELIJAH SHAMBAUGH

## 3. (b) Social Security Number

213-10-6766

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Autumn  
 7. Birth date of deceased (mo., day, yr.) July 22 1877  
 5.(c) If alive, give age 63 years  
 8. AGE: Year 69 Month 11 Days 25 If less than one day  
 hrs. min.

9. Birthplace Magnolia Morgan Co. W. Va.  
 (Town, county, and state)  
 10. Usual occupation Asst. Operator  
 11. Industry or business No. Amer Cement Corp Power House

FATHER 12. Name Albert Shambaugh  
 13. Birthplace Magnolia W. Va.  
 MOTHER 14. Maiden name Virginia Wissner  
 15. Birthplace Magnolia W. Va.

16. Informant James L. Shambaugh  
 Address Hagerstown Md.

17. Burial Date thereof 7/20/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. July 20. 47 Charles Powers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1947 19. at 9.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. to 19.  
 and that I last saw h. alive on 19.

Immediate cause of death. DURATION

acute coronary occlusion

Due to.

Due to.

Other conditions.

(Include pregnancy within 3 months of death)

Major findings of operations.

Date of op.

Autopsy results. No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. No Date of.

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Robert Wells DEPUTY MEDICAL EXAM.  
Hagerstown, Md. WASH. CO., MD.  
 Address Date signed July 19 47

RECEIVED  
JUL 22 1947  
BUREAU 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (In the correct age is especially important. Physicians: please write the causes of death clearly and legibly)

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06373

159

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 36 years  
 Hospital, institution, or street address where death occurred:  
734 West Franklin Street  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 734 West Franklin Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

John C. Shannon

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower  
 6. (b) Name of husband or wife Carrie G. Shannon  
 7. Birth date of deceased (mo., day, yr.) March 19, 1871  
 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 76 Months 4 Days 0 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Mt. Holly Springs, Pa.  
 (Town, county, and state)  
 10. Usual occupation Mechanic  
 11. Industry or business

12. Name James Shannon  
 13. Birthplace Cumberland County, Penna.  
 14. Maiden name Delia Sheetz  
 15. Birthplace Adams County, Penna.  
 16. Informant James G. Shannon  
 Address Hagerstown, Maryland

17. Burial 7-20-47  
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)  
 Cemetery or crematory Mt. Holly Spring Cemetery  
 Location Mt. Holly Spring, Pa.

18. Funeral director C. M. Suter & Sons  
 Address Hagerstown, Maryland

19. July 19, 1947 Beach Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 18, 1947 at 11:45 AM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20, 1947 to July 18, 1947  
 and that I last saw him alive on July 17, 1947  
 Immediate cause of death

## DURATION

Heart Block - Partial  
 Due to Partial  
 Due to  
 Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Harold R. Bowers M. D. or other  
 Address Hagerstown Md Date signed 7/19/47

RECEIVED  
JUL 22 1947  
BUREAU OF

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

### 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution: 2416 Virginia Ave  
Stay in hospital or inst. (yrs., or mos., or days) None  
Stay in this community (yrs., or mos., or days) Life

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Hagerstown Ward No. None  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. 2416 Virginia Ave  
(If rural give LOCATION)  
2(a) IF VETERAN, NAME WAR None

### 3. (a) FULL NAME

Florence Eva Shoop

### 3. (b) Social Security Number

NONE

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

B (b) Name of husband or wife Clifford H. Shoop  
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) SEPTEMBER 24-1889

8. AGE: Years 58 Months 0 Days 23 If less than one day hrs. min.

9. Birthplace Chambersburg Franklin Co Pa  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Samuel E. Mowers

13. Birthplace Chambersburg Pa

14. Maiden name Patsy Holter

15. Birthplace Chambersburg Pa

16. Informant Clifford H. Shoop

Address Hagerstown MD

17. Burial Date thereof 10/18/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown MD

18. Funeral director Andrew K. Coffman

Address Hagerstown MD

19. Oct. 18, 1947 Registrar Frank Mowers  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH 7/16/47 19 at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/16/47 19 7/16/47 to 7/16/47 19 7/16/47  
and that I last saw her alive on 7/16/47 19 7/16/47

Immediate cause of death Cerebral Reflex DURATION Immediate

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Ralph L. Gering M. D. or other

Address Williamstown, Md Date signed 10/18/47

MARGIN RESERVED FOR BINDING

(I)

VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

RECEIVED

OCT 21 1947

BUREAU 9 A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. hirshman

94a

06374

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 503 Washington Square  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war World War # 1

## 3. (a) FULL NAME

JOHN LEO SPALDING

## 3. (b) Social Security Number

705-10-7409

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Bessie  
 6. (c) If alive, give age 53 years  
 7. Birth date of deceased (mo., day, yr.) October 14 1893  
 8. AGE: Years 53 Months 9 Days 7 If less than one day .hrs. min.

9. Birthplace Point of Rocks Fred. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Conductor  
 11. Industry or business W M.R.R. Yards

FATHER 12. Name Howard J. Spalding  
 13. Birthplace Greenfield Md.  
 MOTHER 14. Maiden name Hattie M. Nichols  
 15. Birthplace Point of Rocks Md.

16. Informant Mrs. Bessie Spalding  
 Address Hagerstown Md.

17. Burial Date thereof 7/23/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rest Haven Cemetery  
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. July 23 1947 Charles Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

P

20. DATE OF DEATH July 21 1947 at 7:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 1947 to July 21 1947  
 and that I last saw h./m. alive on July 16 1947

Immediate cause of death Coronary Occlusion DURATION 2 minutes

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Charles Bowers M. D. or other

Address 154 W. Washington Date signed 7/23/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06375

164

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 Years  
 Hospital, institution, or street address where death occurred:  
153 W. Washington St.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 153 W. Washington St.  
 (If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (a) FULL NAME

Alvin Lewis Staubs3. (b) Social Security Number  
235-12-1398

4. Sex <u>Male</u>	5. Color or race <u>white</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	--

6. (b) Name of husband or wife Mary V. Staubs  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Sept. 8, 1887  
 8. AGE: Years 59 Months 10 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Harpers Ferry W. Va.  
(Town, county, and state)10. Usual occupation Construction Employee

## 11. Industry or business

MOTHER FATHER	12. Name <u>Arron Staubs</u>
	13. Birthplace <u>West Virginia</u>
	14. Maiden name <u>Mary Elizabeth Edwards</u>
15. Birthplace <u>West Virginia</u>	

16. Informant Hazel OrcettAddress 153 W. Washington St. City/17. Burial Date thereof July 22, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Chestnut Grove CemeteryLocation Near Charlestown, W. Va.18. Funeral director Fred W. KraissAddress Hagerstown, Md.19. July 22, 1947 W. Bowers  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

E.D.T.

20. DATE OF DEATH July 20, 1947 1:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_  
 and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death

DURATION

acute coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of \_\_\_\_\_Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE S. Robert Wells DEPUTY MEDICAL EXAM.  
WASH CO., MD.  
M. D. \_\_\_\_\_Address Hagerstown, Md. Date signed 7/21/47

RECEIVED  
JUL 24 1947  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

## CERTIFICATE OF DEATH

Dr. Ralph Young

176

06376

302

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 Weeks  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 4 Weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Williamsport  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Clearyspring  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

MRS MARY SALOME STRALEY

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow  
 6.(b) Name of husband or wife Joseph Straley  
 7. Birth date of deceased (mo., day, yr.) March 17, 1862  
 8. AGE: Years 85 Months 4 Days 13 If less than one day  
 hrs. min.

8. Birthplace Mercersburg, Franklin Co. Pa.  
 (Town, county, and state)

10. Usual occupation House Wife

11. Industry or business Own Home

12. Name William C. Clark

13. Birthplace Mercersburg Pa.

14. Maiden name Ellen M. Shafer

15. Birthplace Mercersburg Pa.

16. Informant Mrs Miles Marsh

Address Williamsport Md.

17. Burial Date thereof 8/1/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory River View Cemetery

Location Williamsport Wash. Co. Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Aug. 1, 47 Registrar Charles Bowers

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 19. 47 at 7:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/30/47 19. 7/31/47

and that I last saw him alive on 7/30/47 19.

Immediate cause of death Acute Toxic R.T. Pneumonia

Due to Hypostatic Pneumonia

Other conditions 5 Days

Other conditions 5 Days

Other conditions 5 Days

Other conditions 5 Days

Other conditions 5 Days

Other conditions 5 Days

Other conditions 5 Days

Other conditions 5 Days

Other conditions 5 Days

Other conditions 5 Days

Other conditions 5 Days

Other conditions 5 Days

Other conditions 5 Days

Other conditions 5 Days

Other conditions 5 Days

Other conditions 5 Days

Other conditions 5 Days

Other conditions 5 Days

Other conditions 5 Days

Other conditions 5 Days

RECEIVED  
AUG 4 1947  
BUREAU C B

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington CountyCity or town... Paramont Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Killed by train

Hospital, institution, or street address where death occurred:

W. M. R. R near ParamontHow long in hospital or institution? Killed by train

## 3. (a) FULL NAME

Paul Oscar Summers

## 3. (b) Social Security Number

705-14-0149

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Sarah Ella L. Summers8. (c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.)

Oct. 12 1917

## 8. AGE:

Years

Months

Days

If less than one day

29823

hrs.

min.

## 9. Birthplace

Frederick Co. Md.

(Town, county, and state)

## 10. Usual occupation

Machine Operator

## 11. Industry or business

Section Gang W. M. R. R

## 12. Name

Charles Hezekiah Summers

## 13. Birthplace

Fred. Co. Md.

## 14. Maiden name

Bertha Hooper

## 15. Birthplace

Frederick Co. Maryland

## 16. Informant

Sarah Ella Summers

## Address

Church St. Williamsport, Md.

## 17. Burial

Date thereof July 8 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

Greenlawn Cemetery

## Location

Williamsport, Maryland

## 18. Funeral director

Edith V. Leaf

## Address

#7 Church St. Williamsport, Md.

## 19. Date rec'd by registrar

July 7, 1947

## 19. Date

1947Blair Bowers

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty WashingtonCity or town Williamsport Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. Church St. Williamsport, Md

(If rural, give LOCATION)

2. (a) If veteran, name war World War #2

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

July 5, 1947, at 11:55 A.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

E.D.T.

19... to... 19...

and that I last saw h... alive on... 19...

## Immediate cause of death

Open fracture of skull  
Open fracture of right femur

## DURATION

Due to...

Due to...

Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. ....

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of 7/5/47

Where did injury occur?

near Reel  
(City or town)Williamsport, Md.  
(State)

Injured at home, farm, industry, public place (where?)

RR tracks

Means of injury

Struck by train

Injured at work?

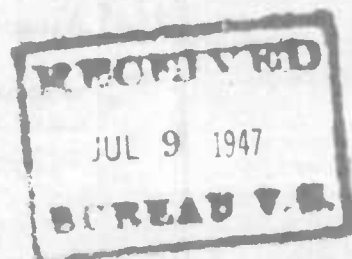
Yes

## 23. SIGNATURE

S. Robert Wee  
Hagerstown, Md. Date signed 7/7/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

166

06378

## CERTIFICATE OF DEATH

Reg. Dist. No. 301

## 1. PLACE OF DEATH: Washington

County.....  
City or town..... Rural Williamsport  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?.....  
Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)State..... Maryland County..... Washington  
City or town..... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 247 S. Potomac St.  
(If rural, give LOCATION)  
-----

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Charles Terzian

## 3. (b) Social Security Number

-----

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... November 24 1898

8. AGE: Years..... 48 Months..... 8 Days..... 4 If less than one day..... hrs. .... min.

9. Birthplace..... Armenia  
(Town, county, and state)

10. Usual occupation..... None

11. Industry or business..... None

12. Name..... Sanakerim Terzian

13. Birthplace..... Armenia

14. Maiden name..... Akhsa Dambrayian

15. Birthplace..... Armenia

16. Informant..... Oscar Miller  
Address..... Chambersburg Pa.17. Burial..... Date thereof..... July 31, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Rest Haven Cemetery

Location..... Hagerstown Md.

19. Funeral director..... Scott F. Minnich &amp; Son

Address..... Hagerstown Md.

19. 7/30 19 47 Mrs. E. Lee McElroy  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION Between

2D. DATE OF DEATH..... July 28 1947 at 1:30 &amp; A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19....., to..... 19.....  
and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Gun shot thru cheek and

Due to..... base of skull

Due to..... (shock)

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op..... July 28 '47

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of..... 7/28/47

Where did injury occur?..... Hagerstown Wash. Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... Williamsport Pa.

Means of injury..... shot .45 Injured at work? No

DEPUTY MEDICAL EXAM.  
S. Robert Wells WASH. CO., MD.

23. SIGNATURE..... M. D. or other

Address..... Hagerstown Md. Date signed..... 7/29/47

RECEIVED  
AUG 1 1947  
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

0637457

93d

ca

Reg. Dist. No. 302

## I. PLACE OF DEATH:

County... Washington County HospitalCity or town... Hagerstown, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

King StreetHow long in hospital or institution? 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Pa. County... FranklinCity or town... R3 Mercersburg, Pa.  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

FRANK LEWIS THOMAS.

## 3. (b) Social Security Number

none

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Widower6.(b) Name of husband or wife wife dead7. Birth date of deceased (mo., day, yr.) April 4 - 1877 5.(c) If alive, give age ..... years8. AGE: Years Months Days If less than one day  
70 3 2 ..... hrs. .... mo.9. Birthplace Hulltown, Co. Pa.  
(Town, county, and state)10. Usual occupation Farmer Retired

11. Industry or business

12. Name Samuel Thomas13. Birthplace Hulltown Co Pa14. Maiden name Jane Burkhardt15. Birthplace Franklin Co Pa16. Informant James ThomasAddress Mercersburg Pa R.D. #17. Buried Date thereof July 19 19 47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory First Home Mercersburg R.D.

Location

18. Funeral director Mr. LiningerAddress Mercersburg, Penna.19. July 17, 19 47 Charles H. Brown  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 19 47 8:53P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPT. 14 19 43 to July 16 19 47  
and that I last saw him alive on July 16 19 47Immediate cause of death CORONARY OCCLUSION  
ACUTE

DURATION

48 hrsDue to ARTERIOSCLEROTIC  
HEART DISEASE

?

Due to .....

?

Other conditions Cholelithiasis

(Include pregnancy within 3 months of death)

Major findings of operations None. Date of op. None.Autopsy results Same.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

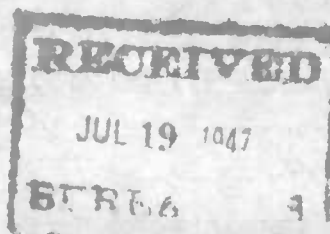
Accident, suicide, or homicide..... Date of .....

Where did injury occur? .....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE Andie Robert Cohen M. D. clearAddress Clear Spring Md Date signed 7-17-47



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

06380

## 1. PLACE OF DEATH

County WashingtonVillage or City BaltimoreRegistration Dist. No. 307

No.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 7 yrs. 0 mos. 0 ds.How long in U. S. if of foreign birth? 0 yrs. 0 mos. 0 ds.2. FULL NAME Edward Richardson Tritapoe

(a) Residence: No.

St.

Ward.

(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

male

## 4. COLOR OR RACE

white

## 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

married5a. If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofIida M. Cordell

## 6. DATE OF BIRTH (month, day, and year)

Dec. 10, 1864

## 7. AGE

Years

Months

Days

If LESS than  
1 day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.83

## OCCUPATION

8. Trade, profession, or particular  
kind of work done, as SPINNER,  
SAWYER, BOOKKEEPER, etc.BOOK Retired9. Industry or business in which  
work was done, as SILK MILL,  
SAW MILL, BANK, etc.Blacksmith10. Date deceased last worked at  
this occupation (month and  
year)11. Total time (years)  
spent in this  
occupation12. BIRTHPLACE (city or town)  
(State or country)Virginia

## MOTHER FATHER

## 13. NAME

Charles Tritapoe14. BIRTHPLACE (city or town)  
(State or country)Virginia

## 15. MAIDEN NAME

Alveta Hough16. BIRTHPLACE (city or town)  
(State or country)Virginia

## 17. INFORMANT

(Address)

Mar. Ida M. Tritapoe  
Brownsville Md.

## 18. BURIAL, CREMATION, OR REMOVAL

BuriedJuly 41947

## 19. UNDERTAKER

(Address)

C. H. Fultz & Bro  
Brownsville Md.

## 20. FILED

July 21947Bernelline W. Diastle  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

July11947

(Month)

(Day)

(Year)

## 22. I HEREBY CERTIFY, that I attended deceased from

May 151947to July 11947

I last saw him alive on

June 301947to have occurred on the date stated above, at 2 1/2 m.The PRINCIPAL CAUSE OF DEATH and related causes of importance  
were as follows:Carcinoma of Liver

Date of onset

2

## Other Contributory Causes of importance:

Arteriosclerosis15 yrs

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

## 23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of injury

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

## 24. Was disease or injury in any way related to occupation or deceased?

If so, specify

(Signed)

(Address)

M. D.



# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923
------------	-------------

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year
-----------------	--------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Ditto

152

06381

Reg. Diat. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown R# 2  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 43 Years  
 Hospital, institution, or street address where death occurred:  
Route 40  
 How long in hospital or institution? ---

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown R#2  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Western Pike  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

COLES MEREDETH WHITTINGTON

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower  
 6.(b) Name of husband or wife Nora  
 6.(c) If alive, give age --- years  
 7. Birth date of deceased (mo., day, yr.) July 11, 1874  
 8. AGE: Years 73 Months 0 Days 0 If less than one day --- hrs. --- min.

9. Birthplace Ridgeway, Berkley Co. W. Va.  
 (Town, county, and state)  
 10. Usual occupation Laborer  
 11. Industry or business ---

12. Name John A. Whittington  
 13. Birthplace Winchester Va.  
 14. Maiden name Elizabeth Dunn  
 15. Birthplace Winchester Va.

16. Informant Walter G. Whittington  
 Address Hagerstown Md. R#2

17. Burial Date thereof 7/13/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. July 12, 1947 Registrar Geoffrey Bowers  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1947 at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-47 19, to 7-11-47 19, and that I last saw him alive on 7-10-47 19.

Immediate cause of death

DURATION

Due to Ch. Myocarditis 6 yrsDue to arteriosclerosis 10 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

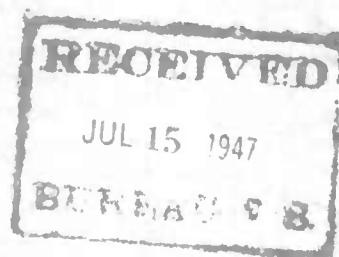
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Ditto M. D. or otherAddress Hagerstown Md. Date signed 7/11/47





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 weeks  
 Hospital, institution, or street address where death occurred:  
Garlock Memorial Convalescent Home  
 How long in hospital or institution? 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Williamsport  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 107 N. Artizan St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Mary M. Winters

## 3. (b) Social Security Number

101 one

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Edward F. Winters  
 7. Birth date of deceased (mo., day, yr.) April 30, 1865  
 6.(c) If alive, give age..... years  
 8. AGE: Years 82 Months 2 Days 20 If less than one day..... hrs. .... min.

9. Birthplace Millstone, Wash. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Home Duties  
 11. Industry or business  
 12. Name Miller  
 13. Birthplace Unknown  
 14. Maiden name Unknown  
 15. Birthplace

16. Informant Mr. Clarence Winters  
 Address Williamsport, Md.  
 17. Burial Date thereof July 23, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Riverview Cemetery  
 Location Williamsport, Md.  
 18. Funeral director Fred W. Kraiss  
 Address Hagerstown, Md.

19. July 22, 1947 Registrar Charles H. Bowser  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1947 19 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1947 to July 20, 1947  
 and that I last saw him alive on 20 July 1947

Immediate cause of death Cerebral hemorrhage DURATION 2 days

Due to Generalized arteriosclerosis

Due to.....

Other conditions Myocardial infarction, 6-7 mo  
Coronary hyperostosis, 3-5 yrs  
 (Include pregnancy within 3 months of death)  
Diabetes mellitus 9 years  
 Major foci of operations Cholecystectomy, 1 mo  
 Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury..... Injured at work?

23. SIGNATURE W. J. Layman M.D. M. D. or other  
 Address 100 Poplar Ave. S.E. Date signed 21 July 47

RECEIVED  
JUN 24 1947  
BUREAU OF